



This document should be shared with and carried by young adults and caregivers.

Date Completed/Last Revised:

Contact Information

Name:		Nickname:	
DOB:		Preferred Language:	
Parent (Caregiver):		Relationship:	
Address:			
Cell #:	Home #:	Best Time to Reach:	
E-Mail:	Best Way to Reach:	Text	Phone Email
Health Insurance/Plan:		Group and ID #:	

Additional Information (hobbies/interests, personal details, other key information):

JIA History

Date of JIA Diagnosis:

Type of JIA	Uveitis History:	Other Complications
<input type="checkbox"/> Oligoarticular persistent <input type="checkbox"/> Oligoarticular extended <input type="checkbox"/> Polyarticular RF negative <input type="checkbox"/> Polyarticular RF negative <input type="checkbox"/> Enthesitis related arthritis <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Systemic JIA <input type="checkbox"/> Unclassified JIA <input type="checkbox"/> Overlap with _____	<input type="checkbox"/> No history of uveitis <input type="checkbox"/> History of uveitis, now inactive <input type="checkbox"/> History of uveitis, active <input type="checkbox"/> Current Eye Provider: <input type="checkbox"/> Date of Last Eye Exam:	<input type="checkbox"/> Macrophage activation syndrome (MAS) <input type="checkbox"/> Cervical spine instability <input type="checkbox"/> TMJ arthritis <input type="checkbox"/> Micrognathia <input type="checkbox"/> Limb length discrepancy <input type="checkbox"/> Sacroiliitis

Infection Risk Screening	Date	Not Done	Positive	Negative	Other Labs	Not done	Positive	Negative
PPD					ANA			
Quantiferon TB					RF			
Hepatitis B					Anti-ccp ab/ACPA			
Hepatitis C					HLA-B27			
HIV								

Current Medications See attached medication list

Takes medications independently: <input type="checkbox"/> yes <input type="checkbox"/> no		Preferred pharmacy:
Performs own injections if applicable: <input type="checkbox"/> yes <input type="checkbox"/> no		
Can obtain refills independently: <input type="checkbox"/> yes <input type="checkbox"/> no		
Medication	Dose	Frequency

Prior JIA Medications	Reason Discontinued
<input type="checkbox"/> NSAID(s):	
<input type="checkbox"/> Hydroxychloroquine	
<input type="checkbox"/> Sulfasalazine:	
<input type="checkbox"/> Cyclosporine	
<input type="checkbox"/> Methotrexate oral	
<input type="checkbox"/> Methotrexate subcutaneous	
<input type="checkbox"/> Leflunomide (Arava)	
<input type="checkbox"/> Etanercept (Enbrel)	
<input type="checkbox"/> Adalimumab (Humira)	

Most Recent Key Labs and Radiology See attached lab and radiology results

Test	Date

Social History

Lives with: _____ Educational/vocational goals: _____

Risk Behaviors	Yes	Yes	Not Asked
Uses tobacco			
Uses other drugs			
Discussed sexual activity			
Discussed contraception			

Other Health Care Providers

Type	Name	Phone	Fax
Primary Care			
Eye Provider			

Emergency Care Plan

Emergency contact name: _____

Relationship: _____ Phone 1: _____ Phone 2: _____

Preferred location for emergency care: _____

Special concerns for emergencies: _____

Signature Patient/Guardian _____ Print Name _____ Date _____

Rheumatology Provider Signature _____ Print Name _____ Date _____

